DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

07 December 2017 C90218

Mackenzie Valgre
fyi-request-6766-027a967a@requests.fyi.org.nz

Dear Ms Valgre

Thank you for your email of 29 October 2017, requesting a copy of Corrections' 'Caring for Prisoners At Risk – A Guide for Staff'. Your request has been considered under the Official Information Act 1982 (OIA).

As you mention, this guide is referenced in the report by the Office of the Ombudsman, 'A question of restraint'. I understand that the guide is a support booklet that is used in the At Risk training implemented in 2011. As identified in the Ombudsman's report, it summarises Corrections' approach to caring for prisoners at risk, and briefly covers mental health disorders.

Please note that as the guide is dated 2 August 2010, it will be under review as part of the Department's Intervention and Support Project.

A Corrections study, released in 2016, found that prisoners have high rates of mental health and substance use disorders. 62 percent of prisoners had some form of mental health or substance abuse disorder in the last 12 months, and 91 percent had a lifetime diagnosis. The disorders often went undetected or were not treated properly in the community.

Corrections has a duty of care to all prisoners and we are actively working to improve prisoners' mental health. This includes a $14 million investment in mental health services and the $300 million redevelopment of Auckland Prison, to enhance safety and security, and to better address prisoners' mental health needs.

More detailed information regarding our plans for investment in mental health can be found on the Corrections website, via the link below:
http://www.corrections.govt.nz/resources/strategic_reports/investing_in_better_mental_health_for_offenders.html

Corrections is committed to preventing unnatural deaths and life threatening incidents of self-harm in prisons. In October 2016, we began a project Transforming the Management of At Risk prisoners. The project recognises that prisoners considered to be 'at risk' have widely differing needs and contemplates a plan for the appropriate management of these prisoners.

In Budget 2017, Corrections received $11.6 million, to be spent over four years, to transform how prisoners at-risk of suicide and self-harm are managed within the prison environment. An Intervention and Support Project has recently been established with the overall intent of creating a therapeutic, needs based approach for these prisoners, with a graduated, multi-disciplinary response focused on intervention and support.

The project will focus on three key areas:

- developing a model of care
- establishing the requirements for the best physical environment in which to manage and treat these vulnerable prisoners
- increasing staff capability to identify, respond to, and manage these prisoners.

As part of the project, we will be looking at all the related training and communication artefacts relating to suicide and harm.

The funding we received will enable us to pilot in three sites – Auckland Men's Prison, Christchurch Men's Prison and Auckland Region Women's Corrections Facility. We intend to design a national service that can be tested and then delivered to additional sites in the future. The model will disrupt a pathway of escalating prisoner mental health issues, which can have significant flow-on effects for the prisoners, their families/whanau, our staff, and wider society.

The new 'whole of prison' model of care for at risk prisoners will primarily be delivered by new multi-disciplinary teams comprising psychologists, occupational therapists, mental health clinicians, social workers and cultural workers. It will involve:

- improved screening and assessment tools
- transforming existing at risk units into specialized intervention and support units (ISUs) including physical enhancements to soften the look and feel of the units
- therapeutic intervention and support plans for prisoners in ISUs, including increased support to transition back into the wider prison environment
- intervention and support plans for at risk prisoners who can be accommodated in mainstream units.

Please find a copy of 'Caring for Prisoners at Risk – A Guide for Staff' attached.

Should you have any concerns with this response, I would encourage you to raise these with the Department. Alternatively you are advised of your right to also raise any concerns with the Office of the Ombudsman. Contact details are: Office of the Ombudsman, PO Box 10152, Wellington 6143.

Yours sincerely

Richard Waggott
Deputy Chief Executive
Corporate Services

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www.corrections.govt.nz

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Caring for Prisoners At Risk

A Guide for Staff

Contents

At Risk Assessment – quick reference guide

High suicide risk circumstances

First prison experience
Current intoxication from alcohol or drugs
Detoxification from alcohol or drugs
Remand, waiting for trial
Remand, waiting for sentencing especially if likely to be long
Charges for violent or sexual offending
First 6 months of imprisonment
Family history of suicide

Suicidal thoughts and plans

Asking a person about their suicide intentions will not increase the likelihood of an attempt. Calmly and matter-of-factly ask about suicide. Further questions to consider asking are:
Are you feeling very low at the moment?
Do you have any thoughts that life is not worth living?
Do you wish that you were dead?
Have you made any specific plans to end your life?
Have you thought about how you would end your life?
Suicide risk increases as a person moves from thoughts to intentions to actions.

Suicide attempts

A major predictor of future suicide risk is previous suicide attempts. The more recent the attempt, and the greater the similarity of context, the greater is the likelihood of another attempt.
Has all the secondary information, such as forensic, CPS and psychological reports been identified?
Have nursing staff checked the prisoner's medical records for mental health problems?
If there has been a previous self harm attempt:
- **how many attempts and how serious have these been?**
- **when did these occur?**
- **when was the last attempt?**
- **What were the circumstances of the most recent / most serious suicide attempt?**

Suicidal behaviour

Not everyone who wants to kill themselves will reveal their true intentions. A mis-match between current circumstances and current behaviour may indicate that something is wrong.
Does their current behaviour match their current circumstances?
Are they forward-thinking—talking about future plans or life after their release from prison?
Does their behaviour or presentation match what they are saying?
What clues or cues can you see, especially from their body language?

Check these off

- ✓ Include others in your decision on whether a prisoner is at risk of suicide or self harm.
- ✓ Talk to a nurse about any risk alerts (drug use, self harm attempts etc).
- ✓ Ensure you have all information needed and everything has been covered in the assessment.
- ✓ Provide a narrative and evidence of your observations, such as "Prisoner seemed low as he was not talking much with little eye contact".
- ✓ Document your decision clearly in IOMS, explaining why you have determined the prisoner is at risk or not at this time.
- ✓ Write your summary so an independent person can read it and understand why you made your decision.
- ✓ Ensure that your decision is reasonable and robust at the time.

If any signs give you concern, place the prisoner "At Risk" and follow PSOM procedures.

4 Stage Listening Contd.

Stage Four– Check how the action worked

- Arrange another interview
- You can check quickly if the action plan worked
- If the plan worked—fine. If not, you may need to explore why not, and plan other options
- The most important part of this stage of reworking the plan is to let the prisoner suggest options.

5 Rules for Describing Interviews

- Focus on behaviour rather than the person
- Focus on observations rather than inference
- Focus on description rather than judgement
- Focus on the here and now rather than there and then
- Focus on what is said rather than why it is said.

The Department's Philosophy

The Department of Corrections acknowledges that all prisoners by virtue of being in prison pose an increased risk of self harm or suicide.

Definition of At Risk

- A prisoner who has been assessed as being "at risk" of harming themselves..
  - Self harming behaviour (range of behaviours from cutting to actions which are intended to lead to death)

Primary Principles

- Everyone is responsible for the early identification of a prisoner's at risk status and for taking immediate action when such risks are identified.
- The level of risk presented by the prisoner should be minimised as quickly and safely as possible.

Key Principles of Policy

- Care is central to everything we do and can only be achieved through effective multi-disciplinary teamwork
- Everyone in the prison community must take immediate action when risk is identified
- Decisions about At Risk Prisoners must be made by teams and not individuals
- All staff are required to be vigilant and recognise that a prisoner is in crisis and their behaviour may unsettle other prisoners
- Since assessment techniques alone are not enough to prevent suicides, there is a need to create a context where prisoners feel safe and confident to ask for help.

Current Statistics

- Between 2006 and 2009, there were 17 prisoner suicides in custody. At least 190 prisoner's lives have been saved in the same period (this number relates to self harm incidents where the individual would been unlikely to survive without intervention)
- Hanging was the method most commonly used.
- Over 70% used their bed sheets as 'rope'
- Air ventilation grills were the most common hanging point
- 90% were committed in maximum or high security units—this is likely to be linked to violent offenders, who are not afraid to act on these tendencies, being more likely to commit suicide
- Male prisoners were more likely to take their own lives
- Suicides were more likely to occur in the first six months of incarceration. 35% were in remand; 65% sentenced
- Prisoners with a history of suicide and self harm attempts are more likely to take their own lives
- While not totally definitive, prisoners aged 35-39 presented as the most common age group, followed by 18-19, 20-24 and 25-29
- Both Maori and NZ European were equally represented in the suicides
- 41% of suicides occurred during October and November
- 11 of the 17 suicides were by prisoners who were drug users, either recreational or prescribed.

4 Stage Listening

4-Stage listening is a model to help people to solve their own problems:

- The stages are separate and you don't have to go through all of them
- Often Stage 1 is enough—it will make people feel heard
- Sometimes it is better to refer a prisoner on for stages 2 & 3, and come back for Stage 4
- But sometimes we need to "seize the moment".

Stage One—Explore the problem

- Just listen actively while the prisoner talks (this may take longer than most people allow)—use your listening skills
- Avoid questions as far as possible
- Use "follow-ons" and encouragements only to persuade the prisoner to keep talking.

Stage Two – Focus And Share Perspectives

- Carry on listening actively
- Encourage the prisoner to focus on the most important parts of their problem
- e.g. give some information that would help them, or ask a few more questions to get them thinking
- Don't advise or problem solve for them.

Stage Three – Help The Prisoner To Plan Action

- Carry on listening actively
- The pace may become more "business like" here
- Encourage the prisoner to take the initiative in planning what they want to do
- You may have some suggestions, but don't overdo it.

Suicide Risk After Self-Harm or Attempted Suicide

Some people

- Use self harm as a coping strategy with no plans of suicide
- Use self harm as a way of communicating intense distress to others
- Suicide risk is higher in people who make a number of suicide attempts with increasing frequency and increasing seriousness
- The risk of suicide following a suicide attempt is 100 times that of the general population.

Listening Challenges

Be aware of the challenges you need to overcome:

- (other) prisoners putting demands on you
- Sorting out practicalities
- Having to do At Risk assessments in a very short time
- Being tempted to listen "so far and no further"
- Coming up with advice or a practical solution and stop listening.

When helping someone, try listening for longer

- Relax
- Slow down
- Offer time
- Use active listening.

Take time to listen before you:

- Offer practical help
- Discuss what the prisoner should do
- Ask about suicidal intentions (but get to this when appropriate).

Recognising Risk— When to be Concerned

Assessment of At Risk Status

Assessing suicidal risk is not an exact science especially within the prison setting, as prisoners can present with a number of predisposing factors such as drug misuse and mental health problems.

Assessment is a dynamic process where levels of risk ***often change****. All prisoners are vulnerable to some degree and often give "clues" when they are worried. Sometimes there are "cues" in their personal histories (the predisposing factors), which can lead us to the view that they are especially vulnerable. We need to be aware of these "clues and cues".*

People who attempt or commit suicide often show distress or intent that can be detected by observing, listening and asking. Be aware that some may conceal their intent. Consider what the person says and does.

Distress signals—ask the person about them

Characteristics of Prison Increasing the Risk of Suicide

- Authoritarian environment
- No apparent control over future
- Isolation from friends, family, community
- Shame of imprisonment
- Dehumanising effects of imprisonment
- Fears
- Staff insensitivity to arrest and imprisonment
- Negative expectations about short term / long term future
- Sense of hopelessness

Behaviours to watch for

- Crying, emotional outbursts
- Recent suicide attempt
- Giving away possessions
- Withdrawal from social contact
- Self neglect (e.g. not eating)
- Not planning for release
- Increase in frequency or lethality of self harm
- Alcohol / Drug abuse
- Irrational behaviour, out of touch with reality
- Recklessness / fighting
- Hostile rejections of help

Thoughts

- “There’s no point…”
- “I can’t take it any more.”
- “I wish I were dead.”
- “Everyone would be better off without me.”
- “I just want it to be over.”
- “Nothing will ever get better.”
- “There’s no future for me.”

Factors

Factor which make suicide more likely

- Immediate intention to carry out suicide
- Specific plan of suicide
- Choice of violent method of suicide e.g. hanging
- Access to means of committing suicide
- Plans for death e.g. will changes, family farewells
- Recent escalation of:
  - Suicidal behaviour e.g. self harm
  - Help seeking behaviour e.g. seeing the chaplain
  - Current symptoms of mental disorder
- Past high-risk suicide attempt
- Likelihood of bad news—’the last straw’
- A self imposed deadline passes without the good news the prisoner hoped for.

Factors which make suicide less likely

- Looking forward to future events
- A statement from the prisoner that he/she will not commit suicide if an event occurs. However, this lowers immediate risk only. Beware if the event is not under the prisoner’s control e.g. “I will not commit suicide if my wife comes back to me before I go to court.”
- Fear of:
  - Death
  - Being left physically / mentally damaged
  - Attempt having no effect on family / friends
  - No-one to look after children / significant others
  - No access to means of suicide.

Avoid Ambiguous Questions

Some people are not direct enough in their questioning because they feel too embarrassed or awkward asking about suicide plans for fear of giving the person the idea.

- You cannot plant the idea if it was not there before
- Prisoners who are feeling suicidal are more likely to be comfortable talking about it if you are comfortable asking them
- Most reveal suicide intent when questioned directly by a sympathetic interviewer
- Only a minority of people deny suicidal intent when in fact they are planning suicide.

Ambiguous questioning may receive an unclear answer e.g. “Have you thought about doing something silly?”

- A “yes” response may be interpreted as suicidal ideation when in fact the prisoner may have been thinking of escape or picking a fight
- Your idea of “something silly’ may not be what the prisoner thinks on as “something silly”
- So be clear and direct.

Feelings expressed

- Desperate
- Angry
- Sad
- Ashamed
- Hopeless
- Worthless
- Lonely
- Disconnected
- Powerless

Physical changes

- Lack of interest / pleasure in everything
- Lack of physical energy for no apparent reason
- Disturbed sleep
- Change / loss of appetite, weight
- Increase in minor illness

Situations / triggers

- Relationship problems
- Recent suicide of someone close to them
- Violence, bullying or fear of these
- Parole refusal or other knock back
- Longer sentence than expected

Times of Heightened Risk

- First 24 hours of confinement
- Intoxication/withdrawal
- Waiting for trial
- Pre / Post Court appearances
- Sentencing, especially if sentence likely to be harsh
- Impending release
- Night and weekends – times when staff numbers likely to be lower
- Bad news from family, friends, community
- First 30 days after imprisonment or movement to new facility
- For pre-trial offenders, 60 days after imprisonment
- 4-5 years for long term sentenced violent offenders
- Periods of isolation

Explore Hopelessness

Hopelessness is the best predictor of suicide. Hopelessness is:

- Characterised by feelings that the current situation is not only intolerable right now, but will never improve in the future
  - "Do you think your life could ever get better?"
- Often associated with helplessness.

- Explore whether the prisoner believes anybody can help to improve the current situation
- If a prisoner describes a degree of hopelessness or helplessness, or if you have reason to believe a prisoner to be suicidal, you should specifically ask about thoughts of suicide
- Does the prisoner have anything to look forward to? While prisoners who look forward to an event are less likely to commit suicide in the immediate future, be careful when prisoners plan to live until they have seen through a particular event e.g. birthday, before committing suicide.

Wishes to be Dead

Active wishes to kill oneself are more serious than passive wishes to be dead e.g. "I just wish I could just go to sleep and not wake up".

Specific Plans for Suicide

- Has the prisoner had thoughts about harming or killing him / herself?
- Are these thoughts fleeting or persistent?
- Does the prisoner have any specific plans e.g. how, where, when, etc.?

Clarification of Current Problems

Find out and clarify problems over the last few months and the last 24 hours. You should check if there are problems relating to the following that the prisoner has not spontaneously mentioned:

- Relationship with partner, other family members, friends
- Social isolation
- Bereavement
- Separation
- Legal, including current court / police proceedings
- Physical health
- Use of illicit drugs / alcohol
- Mental health.

Specific Questioning About Suicidal Intent

- Asking someone about suicidal thoughts will not plant an idea that was not there before
- Most people who are contemplating suicide feel relieved to be able to talk about it
- You cannot assess suicide risk without specific questioning
- Specific information will help if you need to refer the prisoner to other professionals—it may even speed up the process.

Making an Initial Response (In the Residential Unit)

- Talk to the person. Ask them about what you are concerned about. Comment on behaviour: “You’re looking really low. Is anything wrong?”. Ask about events: “You were in court today weren’t you. How did it go?” Give broad openings: “Tell me about it…. You look like you need to talk things over with someone.”
- Take time to listen. Talking about a problem is a strength, not a weakness.
- Do not feel you need to solve the problem—support is delivered by a good team, not just an individual.
- Check out how bad the person is feeling.
- If you suspect the prisoner might be thinking of suicide, ask them as directly as possible: “Are you thinking about suicide?” Or “Is it so bad you are thinking of killing yourself?”
- If there is risk, don’t leave the person alone. Alert other staff—custodial and Health.
- Begin a Review Risk Assessment.

Be aware that some people may conceal their intent. Consider both what the person says and also what they do.

Talking about suicide with someone will give them the opportunity to:

- Express their feelings
- Give them a sense of relief
- Discover a reason to live

Talking about suicide will not cause someone to do it.

Demonstrate acceptance of the prisoner

- Non-verbal communication encourages the prisoner to speak:
  - Nodding
  - Saying “uh-huh”
  - Eye contact (be aware of cultural norms though)
- Reflect or paraphrase what the prisoner says and empathise. This helps the prisoner speak about difficult issues:
  - “I can see that things have been very difficult for you lately”

Clarify ambiguities

- Sometimes prisoners do not express themselves very clearly. Clarify a prisoner’s subjective experience:
  - “What exactly do you mean by ‘wound up’?”

Summarise

Go over what has been discussed and ask if it is correct. This:

- Enables the prisoner to correct any misconceptions or factual inconsistencies
- Shows the prisoner you have been listening
- Shows you are taking the problems seriously
- Gives some hope to the prisoner that his/her situation can improve.

Questioning Style

- Start off with open questions i.e. questions that get the prisoner talking
- Avoid 'why' questions at first—these can involve opinion rather than fact
- Avoid questions that can be answered with only 'yes' or 'no'. These have the effect of shutting the prisoner down
- Listen more than you question—the prisoner should do most of the talking at first
- Once the prisoner speaks about specific problems, ask direct questions to obtain the information needed
- Use closed questions—able to be answered with 'yes' or 'no' - only to clarify facts.

Pick up verbal and non-verbal cues

Pay attention to:

- Key words or phrases that refer to emotional topics and social information:
  - "I have been feeling very wound up lately"
- Non-verbal signs of possible emotional disorder:
  - Tearfulness
  - Signs
  - Agitation
  - Restlessness
  - Pacing
  - Lack of eye contact (be aware of cultural norms though)
  - Slouched posture.

Reception into a Prison

Assessment Tools

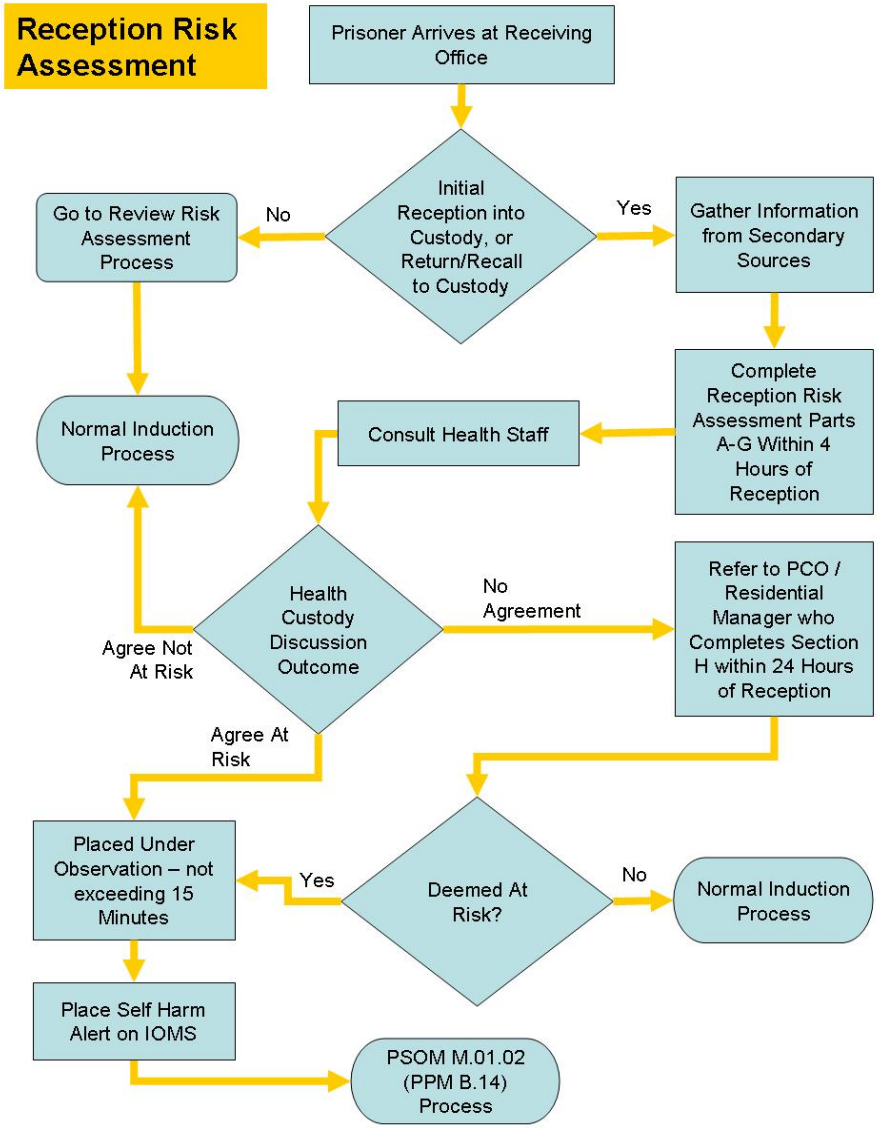
- Reception Risk Assessment

Reception Risk Assessment

- The Reception Risk Assessment is designed to assess the at risk status of prisoners newly arrived at a prison. It will be administered by Receiving Office staff.
- The policy for its use and application is in the Prison Operations Manual (POM) in section M.05.01.

Review Risk Assessment

- The Review Risk Assessment is designed to assess the at risk status of prisoners already incarcerated at a prison. It will be administered by Receiving Office staff only when a prisoner returns from court. In all other instances, it will be administered by Unit custody staff.
- The policy for its use and application is in the Prison Operations Manual (POM) in section M.05.02.



Interviewing At Risk Prisoners

- Establishing rapport
- Questioning style
- Pick up verbal and non-verbal cues
- Demonstrate acceptance of the prisoner
- Clarify ambiguities
- Summarise

Establishing Rapport

"Active Listening" means:

- Introduce yourself by name
- Explain what will happen, why, and how long it will take
- Interview the prisoner in a quiet setting, if possible
- Arrange the seating appropriately—try to be on the same level
- Maintain eye contact
  - Beware of looking excessively at notes or the computer
  - Be aware of cultural norms about eye contact
- Use the prisoner's name
- Keep the pace of the interview unhurried and not challenging

Reviewing When Things Change

Assessment Tools

- Review Risk Assessment

Review Risk Assessment

- The Review Risk Assessment is designed to assess the at risk status of prisoners already incarcerated at a prison. It will be administered by Receiving Office staff only when a prisoner returns from court. In all other instances, it will be administered by Unit custody staff.
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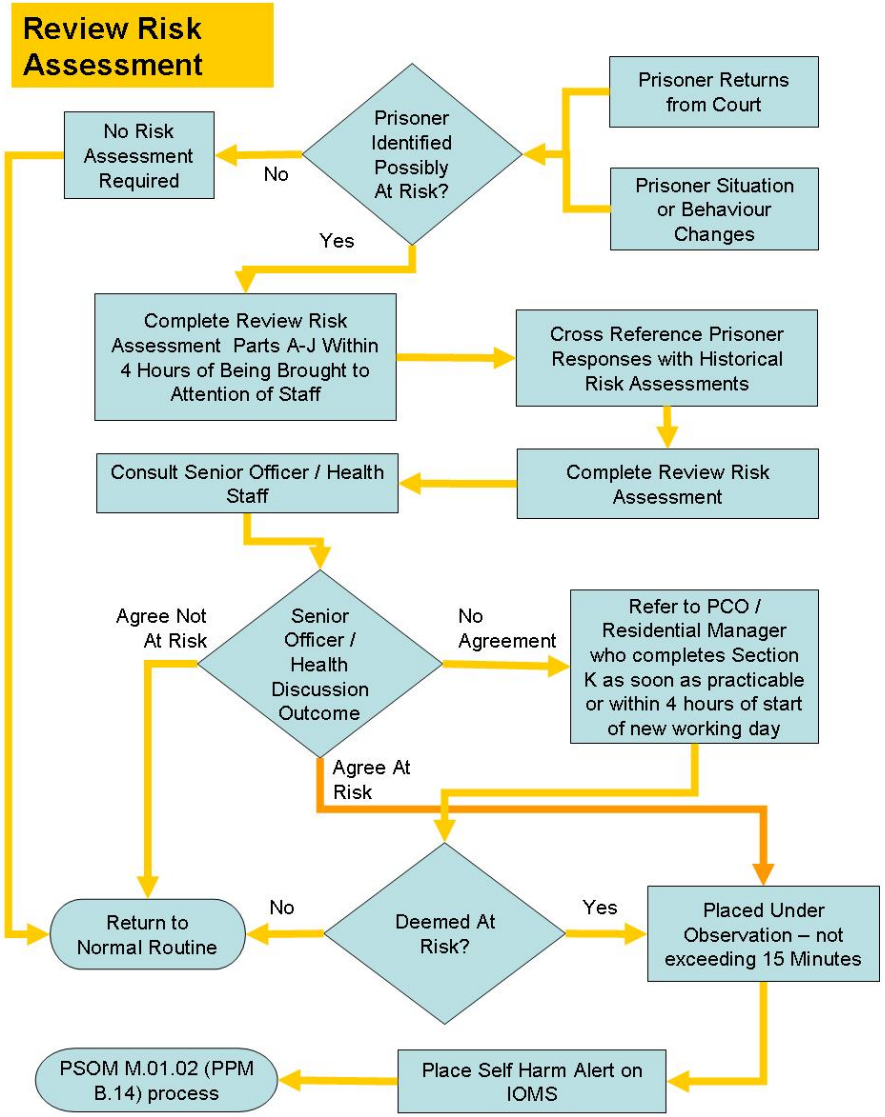

Special Issues for Youth Offenders

Introduction

Youth present a special set of conditions which can lead to suicide or self harm.

The experience of incarceration may be particularly difficult for youth offenders who are separated from their families and friends. Distressed young prisoners are especially dependent on supportive relationships with the staff. Therefore, separating and isolating young prisoners may lead to additional risk for suicidal actions, which can happen at any time of their confinement.

Youth offenders who are placed in adult correctional facilities should be considered to be at particularly high risk of suicide.

An important note for recognition of risk in young people—depressed mood may present as irritable mood.

Another consideration is that many young people are impetuous and may not show any indication of their intention to self harm or suicide. Getting them to talk about how they are feeling is a way of getting them to reveal what actions they may be contemplating.

Mental Health

Introduction

One of the risk factors for suicide is having a mental health illness. The World Health Organisation estimates that 90% of all suicide victims have some kind of mental health condition, often depression or substance abuse. Suicide is a major cause of premature death amongst people with mental illness.

Mental Health in Prison

There is a many types of mental health disorders in a prison setting. These can include:

- Schizophrenia
- Bipolar Affective disorder (previously known as Manic Depression)
- Depression
- Anxiety disorders like:
  - Phobias
  - Obsessive compulsive disorder (OCD)
  - Generalised anxiety disorder (GAD)
  - Post traumatic stress disorder

Alcohol and drug dependence or abuse can co-exist with a mental illness..

Treatment of a mental illness can reduce suicide risk. Suicide tendency can be treated with therapy and medication. Early intervention and effective management appear to reduce the risk over time.

Schizophrenia

Schizophrenia causes severe disruption to a person's thought process.

People with Schizophrenia often experience delusions or hallucinations, in particular auditory hallucinations. Schizophrenia distorts the way a person thinks, feels or perceives things. This may lead to a withdrawal from reality.

Symptoms of schizophrenia may include:

- Changes in personality and thought process
- He or she has difficulty separating what is real from what is not
- Can become isolated and withdrawn
- Deterioration in personal hygiene and how they relate to others.

Acute symptoms of schizophrenia:

- Bizarre delusions
- Exaggerated religious beliefs
- Paranoid ideals
- Hallucinations
- Extreme withdrawal
- Sleep disturbance
- Threats of harm to self or others
- Disruptive, aggressive, suspicious behaviour.

Impact of Suicide or Suicide Attempts on Staff

Introduction

Stress reactions in staff following a suicide or suicide attempt are common and are normal reactions to an abnormal event.

Common Stress Reactions

- Constant thoughts of the suicide incident
- Reluctance to go back to the place it occurred in
- Tension
- A numbness to surroundings
- Inability to eat or sleep
- Constant tiredness
- Apathy, depression
- Irritability, outbursts of anger

What to do to minimise the effects of stress

- Recognise that stress is a normal reaction
- Accept that taking care of yourself is a strength, not a weakness
- Talk about the experience with a colleague, friend, family member or PIRT team
- Take part in debriefing sessions
- Get back to your normal routine as soon as possible. Time out from working with prisoners can sometimes be more helpful than time off work
- Get enough sleep and regular exercise, and eat a healthy diet
- Be more careful when driving or operating machinery. Accidents are more common after severe stress
- Call your PIRT team or EAP.

Six Resiliency Factors

Resilience is the process of adapting well to adverse situations. These factors contribute to counteracting the negative impact of the adverse situations:

- Pro-social bonding
- Clear and consistent boundaries
- Life skills
- Caring and support
- High expectations
- Meaningful participation
- Average or above intelligence.

Depression

Many people who attempt suicide have experienced depression which may also be the result of another mental illness. Types of depression include major depression, bipolar affective disorder and dysthymic disorder.

Symptoms of depression may include:

- Lethargic or lack energy
- Poor concentration and memory
- Changes in appetite—a considerable loss or gain in weight
- Disturbed sleep
- Denial
- Thoughts of suicide—thoughts of worthlessness or extreme guilt
- Reduced level of interest or pleasure in most or all activities.

Major Depression

This is a major mental illness where the person experiences a drop in mood, energy and initiative. They may become so depressed that they consider or attempt suicide. The potential serious consequences of untreated depression and the success of treatment make this an important mental illness to identify.

Bipolar Affective Disorder

Bipolar which means Bi – two; and polar – directly opposite in tendency or nature. The person's mood can cause extremes from deep lows (depression) to highs (mania).

Symptoms of bipolar disorder (mania) may include:

- Increased physical activity
- Becoming interfering or intrusive
- Making elaborate and grand plans
- Spending lavishly and foolishly
- Writing endless letters of complaint
- Reacting violently if beliefs are challenged

Symptoms of bipolar disorder (depressive) may include:

- Lethargic – no energy
- Feeling worthless and or helpless
- Changes in appetite
- Difficulty sleeping
- Poor memory
- Thoughts of suicide
- Anxious or irritable.

Psychosis

Psychosis describes a severe form of mental illness that disorganises and changes the whole personality. People begin to say and do things that other people cannot accept as normal. Reality becomes distorted, judgement and reasoning deteriorate, and mood becomes abnormal experiencing hallucinations.

Symptoms of psychosis may include:

- Delusions
- Hallucination

Delusions

Three types of delusional behaviour are:

- Grandeur
  - the person may believe that they are impossibly rich, talented, powerful or titled.
- Persecution, paranoid
  - the person may believe they are being spied on, poisoned, sexually assaulted, talked about, or having thoughts inserted or removed from their mind.
- Hypochondriac
  - related to bodily functions, for example can't swallow, have cancer.

Hallucinations

The person may hear, smell, taste or feel something that has no basis in reality. This may include the following:

- Visual
  - seeing and talking to others.
- Tactile
  - feeling insects under the skin.
- Auditory
  - voices instructing the person to carry out certain actions.

Obsessive Compulsive Disorders

Obsessive compulsive disorder or OCD is an anxiety disorder. Persistent thoughts, impulses and images that cause anxiety and stress.

Behaviours that act to reduce the stress include:

- Continual hand washing
- Checking routines
- Repetitive praying
- Repetitive counting.

